INDY EAST
PERIODONTICS

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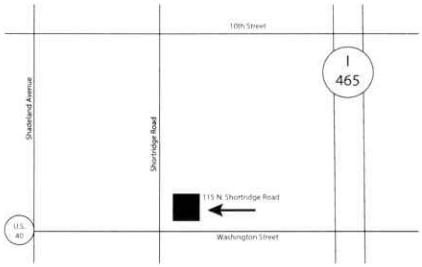

Date_____

Patient _____

Phone_____

Referring Dentist _____

Please Perform:

- ☐ Complete Periodontal Exam
- ☐ Limited Periodontal Exam For_____
- ☐ Implants _____
- ☐ Soft Tissue Graft _____
- ☐ Crown Lengthening _____
- ☐ Extraction with Socket Preservation
- ☐ Osseous Surgery _____
- ☐ Frenectomy _____
- ☐ Ridge Augmentation _____
- ☐ Biopsy
- ☐ CBCT Scan

- ☐ Please Take FMX
- ☐ Sending FMX Date_____
- ☐ Sending PA's for Teeth # _____

Past Root Planing ☐ Yes ☐ No Quads: UR LR UL LL

Date Completed:

Patient's Primary Concern: _____

Initial Restorative Thoughts: _____

Comments: _____